(26) (21)

Nos. 88-805 and 88-1309

Supreme Court, U.S.
FILED
OCT 13 1989
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

STATE OF OHIO,

Appellant,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,

Appellees.

On Appeal from the United States Court of Appeals for the Sixth Circuit;

THE STATE OF MINNESOTA, *et al.*,

Cross Petitioners,

v.

JANET HODGSON, M.D., *et al.*,

Cross Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, THE AMERICAN ACADEMY OF PEDIATRICS, THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, THE AMERICAN NURSES' ASSOCIATION, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE NURSES' ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND THE SOCIETY FOR ADOLESCENT MEDICINE AS *AMICI CURIAE* IN SUPPORT OF APPELLEES IN 88-805 AND IN SUPPORT OF CROSS RESPONDENTS IN 88-1309

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WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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October 13, 1989

QUESTION PRESENTED

Amici curiae will address the following question:

Whether a state can burden a minor's constitutional right to decide whether to terminate her pregnancy by requiring in every case that one or both parents be notified of her decision without providing an effective, confidential and expeditious alternative procedure that does not require parental notification.

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INTEREST OF *AMICI CURIAE*

Amici curiae are eight major organizations of health care professionals. *Amici* share an abiding dedication to promote the public welfare through the maintenance of the highest professional standards and the provision of quality health care. *Amici's* interest is not in debating the philosophical, ethical, moral or religious issues surrounding abortion, but rather in protecting the fundamental right of every individual to make health care treatment decisions free of state interference unless the state has a compelling justification for the restrictions it imposes and the state acts with particular sensitivity in promoting that interest.

Amicus American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians who specialize in obstetric and gynecologic care. ACOG is the leading group of professionals providing health care to women; its 28,000 members represent approximately 90 percent of all obstetricians and gynecologists practicing in the United States.

Amicus American Academy of Child and Adolescent Psychiatry ("AACAP") is a national professional organization of over 4,200 child and adolescent psychiatrists, who engage in research, prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and families.

Amicus American Academy of Pediatrics ("AAP") is a nonprofit association of approximately 30,000 physicians certified in the specialized care of infants, children and adolescents. The AAP's principal purpose is to ensure the attainment by all children of their full potential for physical, emotional and social health. While the AAP's members hold widely divergent views on the desirability of abortion, they share an interest in assuring that state laws regulating abortion not impose unjustified and unnecessary burdens which increase risks to the health or well-being of pregnant adolescents.

Amicus American Medical Women's Association, Inc. ("AMWA") is a nonprofit organization of 12,000 women physicians and medical students. One of AMWA's primary missions is to promote quality health care for women. AMWA strongly opposes laws which adversely affect the health of women, or impose constraints on the right of the pregnant patient, in consultation with her physician, to make a personal and medically informed decision whether or not to continue a pregnancy.

Amicus American Nurses' Association ("ANA") is an association of registered nurses that is dedicated to the advancement of the goals and interests of registered nurses and of the nursing profession generally. The ANA is comprised of 53 member organizations which represent the nation's two million registered nurses. In serving clients of all ages, including adolescents, registered nurses share full information and promote the client's confidentiality.

Amicus American Psychiatric Association ("APA") is the nation's largest professional association specializing in psychiatry, with a membership exceeding 30,000 physicians. APA's purposes include promoting the welfare of patients who require psychiatric services.

Amicus Nurses' Association of the American College of Obstetricians and Gynecologists ("NAACOG"), is a 23,000 member professional organization for nurses who provide health care for women and infants. NAACOG's purpose is to establish relevant nursing standards and to assist its members in supplying the highest quality nursing care to their clients.

Amicus The Society for Adolescent Medicine, is a multidisciplinary association of approximately 1,000 health care professionals. Its purpose is to promote the development, synthesis and dissemination of scientific and scholarly knowledge unique to the development and health care needs of adolescents.

The statutory schemes at issue in these cases, which require notification of one or both parents before a phy-

sician is authorized to perform an abortion on a minor, raise disturbing questions about the provision of health care services to adolescents. In particular, the breach of confidentiality with an adolescent patient that is mandated by these statutes can lead to a significant increase in medical risk for the adolescent by causing her to delay or even to decline to seek care. Accordingly, *amici*, who are the primary providers of health care to young women, wish to present their views concerning the important issues raised in this appeal and cross petition.[1]

MEDICAL BACKGROUND

A. The Pregnancy And Abortion Rates Among Adolescents Are Significant.

Of the approximately 10 million adolescent women between 15 and 19 in the United States, at least 40% are sexually active and over 1 million have become pregnant each year since 1973.[2] In 1985, the most recent year for which complete data are available, the average daily rate of pregnancies was 2,825.[3] Four out of every ten young women will become pregnant at least once in their teens.[4]

National trends show an increase in adolescent pregnancy rates from 1972 to 1982, especially among the youngest adolescents. During that period, the rate of pregnancy among women 15 to 17 years old increased by 12% and the rate for adolescents under age 15 increased by 20%.[5] Since 1982, these pregnancy rates have remained relatively stable.[6]

[1] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

[2] Henshaw & Van Vort, *Patterns and Trends in Teenage Abortion and Pregnancy*, in Alan Guttmacher Institute, Teenage Pregnancy in the United States: The Scope of the Problem and State Responses 12 (1989); National Academy of Sciences, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, Vol. 1, 73 (C. Hayes ed. 1987).

[3] Almost 31,000 of these pregnancies were among teens under age 15. *Henshaw & Van Vort* at 12, 20.

[4] *National Academy of Sciences* at 51.

Approximately 40% of pregnant adolescents each year terminate their pregnancies by an induced abortion.[7] In 1985, 416,170 adolescents terminated their pregnancies; 16,970 of these minors were under age 15.[8] Adolescents obtained 26% of all abortions in 1985. Although younger adolescents are less likely to become pregnant, when they do, they are somewhat more likely than older adolescents to obtain an abortion. Henshaw & Van Vort, *Patterns and Trends in Teenage Abortion and Pregnancy*, in Alan Guttmacher Institute, Teenage Pregnancy in the United States: The Scope of the Problem and State Responses 11-12 (1989).

B. Pregnancy Poses Greater Health Risks To The Woman Than Abortion.

Induced abortion is one of the most common and safest surgical procedures in the United States.[9] The overall risk of dying from abortion is seven times less than the overall risk of dying from childbirth. Greydanus & Railsback, *Abortion in Adolescence*, 1 Sem. Adol. Med. 213, 214 (1985); Cates, Schulz & Grimes, *The Risks Associated With Teenage Abortion*, 309 New Eng. J. Med. 621, 623 (1983). In 1981, the risk of dying from an abortion was 0.5 per 100,000 procedures,[10] while the risk

[5] *Id.* at 16.

[6] *Henshaw & Van Vort* at 12. Birth and abortion rates also have not greatly changed since 1982. *Id.*

[7] *National Academy of Sciences* at 58.

[8] *Henshaw & Van Vort* at 10.

[9] Other common surgical procedures pose much greater risks of death than abortion: a tonsillectomy has two times the risk and an appendectomy carries 100 times the risk of death. W. Hern, *Abortion Practice* 23-24 (1984).

[10] Binkin, *Trends in Induced Legal Abortion Morbidity & Mortality*, 13 Clin. Obstet. Gynec. 83, 85 (1986); *see also* LeBolt, Grimes & Cates, *Mortality From Abortion and Childbirth*, 248 J.A.M.A. 188, 189 (1982).

of dying in childbirth was 8.5 per 100,000 live births.[11] A recent study found no deaths among 170,000 abortions performed within the first 14 weeks of pregnancy.[12]

Nonfatal adverse health effects also occur more often in childbirth than in abortion.[13] Pregnancy presents risks because it not only causes new complications but also aggravates existing conditions.[14] In fact, appropriate treatment for some preexisting illnesses may be termination of the pregnancy. Hunter, *Time Limits on Abortion*, in Reproductive Laws for the 1990s 133 (S. Cohen & N. Taub eds. 1989).

While abortion may involve adverse health effects, they are less frequent and less severe than those of pregnancy and childbirth. Common effects from abortion are pain, headache and nausea. Minor complications, such as infections, occur about 12% of the time, and about 0.4% of women suffer a major complication, such as hemor-

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[11] U.S. Dep't of Health and Human Services, 2A *Vital Statistics of the United States 1981* 64.

[12] Hakim-Elahi & Tovell, *Complications of First-Trimester Abortion: A Report of 170,000 Cases*, in The American College of Obstetricians and Gynecologists, Abstracts of Current Clinical and Basic Investigation 20, 20 (1989).

[13] While 63% of women experience medical complications in pregnancy, Placek & Taffel, *Recent Patterns in Cesarean Delivery in the United States*, 15 Obstet. Gynec. Clin. N.A. 607, 612, 615 (1988), approximately 12% of abortions result in a medical complication. Cates & Grimes, *Morbidity and Mortality of Abortion in the United States*, in Abortion and Sterilization: Medical and Social Aspects 159 (J. Hodgson ed. 1981). *See also* U.S. Dep't of Health and Human Services, Centers for Disease Control, *Induced Terminations of Pregnancy: Reporting States, 1985 and 1986*, 37 Monthly Vital Statistics Rep. 7 (1989) (3.3 complications per 1,000 abortions).

[14] For example, pregnancy may increase the risk of death up to 50% for a woman suffering from a congenital heart disease. D. Danforth & J. Scott, *Obstetrics & Gynecology* 494-97 (5th ed. 1986); *Abortion, Medicine & the Law* 251 (J. Butler & D. Walbert 3d ed. 1986).

rhage severe enough to require a blood transfusion.[15] A recent study of first-trimester abortions reported a total complication rate of less than one percent.[16] Several factors affect the risk of complications from abortion, including the gestational age of the fetus and the woman's age. Buehler, Schulz, Grimes & Hogue, *The Risk of Serious Complications from Induced Abortion: Do Personal Characteristics Make a Difference?*, 153 Am. J. Obstet. Gynec. 14, 19 (1985).

C. Adolescent Pregnancy Poses Particular Medical Risks, Which are Due Largely To Delay In Seeking Health Care.

Pregnancy poses unique, significant risks to the adolescent female compared to the adult woman. Although the rates of mortality and morbidity from abortion are generally lower for adolescents than for older pregnant women,[17] the maternal mortality rate during childbirth is higher for adolescents than older women.[18] Adolescents

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[15] Buehler, Schulz, Grimes & Hogue, *The Risk of Serious Complications from Induced Abortion: Do Personal Characteristics Make a Difference?*, 153 Am. J. Obstet. Gynec. 14, 16 (1985); *Cates & Grimes* at 159-60.

[16] *Hakim-Elahi & Tovell* at 20. *See also* Grimes, *Surgical Management of Abortion*, in Te Linde's Operative Gynecology 533 (R. Mattingly & J. Thompson eds. 1985) (fewer than two serious complications per 1,000 abortions performed by suction curettage method).

[17] Stephenson, *Pregnancy Testing and Counseling*, 36 Ped. Clin. N.A. 681, 693 (1989); Greydanus & Railsback, *Abortion in Adolescence*, 1 Sem. Adol. Med. 213, 214 (1985); Cates, Schulz & Grimes, *The Risks Associated With Teenage Abortion*, 309 New Eng. J. Med. 621, 622-23 (1983). Adolescents under 15, however, may face an increased risk of cervical injury in a suction curettage abortion. *Id.* at 622.

[18] Lee & Corpuz, *Teenage Pregnancy: Trend and Impact on Rates of Low Birth Weight and Fetal, Maternal, and Neonatal Mortality in the United States*, 15 Clin. Perinat. 929, 935-936 (1988); Sacker & Neuhoff, *Medical and Psychosocial Risk Factors in the Pregnant Adolescent*, in Pregnancy in Adolescence: Needs, Problems and Management 107, 127 (I. Stuart & C. Wells eds. 1982).

who do not terminate their pregnancies are 200% more likely to die in childbirth than women in their twenties [19] and adolescents under the age of 15 face the highest risks of childbirth. Strikingly, their risk of death in childbirth in 1,000% greater than the risk to women in their twenties. See Sacker & Neuhoff, *Medical and Psychosocial Risk Factors in the Pregnant Adolescent*, in Pregnancy in Adolescence: Needs, Problems and Management 107, 127 (I. Stuart & C. Wells eds. 1982). See also Makinson, *Health Consequences of Teenage Fertility*, 17 Fam. Plann. Persp. 132, 134 (1985).

Certain health risks of pregnancy are highly correlated with youth. For example, adolescents are significantly more likely to have anemia and toxemia during pregnancy than older women.[20] The most frequent complication of adolescent pregnancy is pregnancy-induced hypertension, or preeclampsia.[21] When socioeconomic factors such as poverty, nonmarital status, low education and race are considered,[22] one age-related effect persists:

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[19] Miller & Field, *Adolescent Pregnancy: Critical Review for the Clinician*, 1 Sem. Adol. Med. 195, 199 (1985); Sacker & Neuhoff, *Medical and Psychosocial Risk Factors in the Pregnant Adolescent*, in Pregnancy in Adolescence: Needs, Problems and Management 107, 127 (I. Stuart & C. Wells eds. 1982). *But see Lee & Corpuz* at 938 (review of data from 1966 to 1980 suggests maternal mortality rates increase as maternal age increases).

[20] *Hunter* at 134.

[21] While 8%-10% of all pregnant women suffer from hypertension, C. Pauerstein, *Clinical Obstetrics* 645 (1987), studies show that up to 17% of adolescents have preeclampsia. Strobino, *The Health and Medical Consequences of Adolescent Sexuality and Pregnancy: A Review of the Literature*, in Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, Vol. II, 112-13 (S. Hofferth & C. Hayes eds. 1987).

[22] Other complications seem to be dependent on socioeconomic status rather than age, except perhaps preeclampsia. American Academy of Pediatrics, Committee on Adolescence, *Adolescent Pregnancy*, 83 Pediatrics 132, 133 (1989). However, adolescents as a group tend to have more than one of these high-risk socio-

an increase in low birthweight infants.[23]

The adolescent's delay in seeking health care largely explains the disparity in risks facing the pregnant adolescent as compared to the adult woman.[24] Timely and complete prenatal care reduces the risks of maternal mortality, infant mortality and low birthweight.[25] While most pregnant women begin prenatal care in the first trimester, Brown, *Drawing Women into Prenatal Care*, 21 Fam. Plann. Persp. 73, 74 (1989); see also Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants* 29 (S. Brown ed. 1989), adolescents consistently delay seeking care until relatively late in the pregnancy. See *Brown* at 74; Melton, *Legal Regulation of Adolescent Abortion: Unintended Effects*, 42 Am. Psych. 79, 80 (1987).

The tendency of adolescents to delay seeking health care when they become pregnant obviously affects when

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economic factors. Scholl, Miller, Salmon, Cofsky & Shearer, *Prenatal Care Adequacy and the Outcome of Adolescent Pregnancy: Effects on Weight Gain, Preterm Delivery and Birth Weight*, 69 Obstet. Gynec. 312, 312 (1987).

[23] Low birth weight is highly correlated to infant death and disease. Davis, *Adolescent Pregnancy and Infant Mortality: Isolating the Effects of Race*, 23 Adolescence 899, 901-902 (1988). Young maternal age is also highly associated with premature birth, a major cause of low birth weight. Ryan, *Giving Birth in America, 1988*, 20 Fam. Plann. Persp. 298, 299 (1988).

[24] One reason for the delay is that pregnancy symptoms in the adolescent may not be readily apparent due to irregular menses in adolescents. AAP, Comm. on Adolescence, *Counseling the Adolescent About Pregnancy Options*, 83 Pediatrics 135, 135 (1989); Brown, *Drawing Women Into Prenatal Care*, 21 Fam. Plann. Persp. 73, 75-76 (1989).

[25] Hediger, Scholl, Belsky, Ances & Salmon, *Patterns of Weight Gain in Adolescent Pregnancy: Effects On Birth Weight and Preterm Delivery*, 74 Obstet. Gynec. 6, 9 (1989); Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants* 18 (S. Brown ed. 1989); AAP, *Adolescent Pregnancy*, at 133; Slap & Schwartz, *Risk Factors for Low Birth Weight to Adolescent Mothers*, 10 J. Adol. Health Care 267, 271-73 (1989); *Davis* at 901; *Pediatrics* 100 (A. Rudolph 18th ed. 1987).

pregnant adolescents typically seek an abortion. Adolescents are twice as likely as other pregnant women to obtain an abortion in the second trimester. U.S. Dep't of Health and Human Services, Centers for Disease Control, *Abortion Surveillance 1982-83*, 36 M.M.W.R. 39 (Feb. 1987). This increased likelihood of adolescents to delay obtaining an abortion increases the risks of the procedure.[26] The risk of mortality from abortion increases 50% for each week after the eighth week of pregnancy.[27]

D. Proper Treatment And Counseling Of Adolescents Requires Individualized Consideration Of Their Special Needs And Developmental Characteristics.

A vital concern of the adolescent who requires medical diagnosis, counseling and treatment for her pregnancy is the confidentiality of her relationship with a health care provider. Confidentiality is important in all relationships between patients and health care professionals, because successful treatment contemplates a relationship that facilitates communication and the flow of accurate information. In the optimal relationship, the health care provider recognizes the patient's rights of confidentiality, respect, dignity and privacy. The American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 89 (7th ed. 1989). The maintenance of confidentiality has long been recognized as vital to all such relationships, but it is particularly important for the adolescent patient.

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[26] *Greydanus & Railsback* at 216; Cates, *Abortions for Teenagers*, in Abortion and Sterilization: Medical and Social Aspects 140, 144 (J. Hodgson ed. 1981).

[27] *Cates & Grimes*, at 155, 171. Compared to the risk of death from abortion at eight weeks, the risk at 9-10 weeks is 2.6 times greater, at 11-12 weeks is 4.2 times greater, and at 13-15 weeks is 9.6 times greater. Grimes, *Surgical Management of Abortion* at 537. *See also* Cates, Schulz, Grimes & Tyler, *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Plann. Persp. 266, 267 (1977) (major complication rate for abortions increases 91% from the eighth to the twelfth week).

A consortium of professional health care organizations, including several of the *amici*, recently adopted a formal policy statement calling on all health care professionals to safeguard the confidentiality of the relationship with the adolescent patient.[28] This policy statement endorses efforts by health care providers to encourage adolescents to seek parental involvement where appropriate, but stresses the overall importance of confidentiality to assure health care treatment. One of the primary reasons cited by the statement for the need to assure the adolescent patient that her confidentiality will be maintained is the direct connection between an adolescent's willingness to seek health care and unqualified assurances of confidentiality.[29] The necessity of ensuring a confidential relationship between the health care provider and an adolescent patient is thus widely recognized within the community of health care professionals.[30]

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[28] *Confidentiality in Adolescent Health Care*, Joint Policy Statement, approved as policy by the American Academy of Family Physicians, *amicus* AAP, *amicus* ACOG, *amicus* NAACOG and the National Medical Association (1988) (reprinted as Appendix 1).

[29] *Id. See also, Brown* at 76 (adolescents typically cite fear of breach of confidentiality as a major reason for not seeking early prenatal care); Melton, *Legal Regulation of Adolescent Abortion: Unintended Effects*, 42 Am. Psych. 79, 80 (1987); Fisher, Marks, Trieller & Brody, *Are Adolescents Able and Willing To Pay the Fee for Confidential Health Care?*, 107 J. Pediat. 480, 482 (1985); Fost, *Parents as Decision Makers for Children*, 13 Primary Care 285, 290 (1986).

[30] *See Adolescent Medicine* 23-24 (A. Hofmann & D. Greydanus 2d ed. 1989); Croxton, Churchill & Fellin, *Counseling Minors Without Parental Consent*, 67 Child Welfare 3, 11 (1988); Anglin, *Interviewing Guidelines for the Clinical Evaluation of Adolescent Substance Abuse*, 34 Ped. Clin. N.A. 381, 394-95 (1987); Silber, *Ethical and Legal Issues in Adolescent Pregnancy*, 14 Clin. Perinat. 265, 269 (1987); Working Group of the Northern Health Region in Current Medical/Ethical Problems, *Consent to Treatment By Parents and Children*, 12 Child 5, 9 (1986); Cavanaugh, *Obtaining a Personal and Confidential History from Adolescents*, 7 J. Adol. Health Care 118, 119 (1986); Lovett & Wald, *Physician Attitudes Toward Confidential Care for Adolescents*, 106 J. Pediat. 517, 519, 521 (1985); Strasburger, Eisner, Tilson, Rigg & Kulig, *Teen-*

Proper treatment for the pregnant adolescent includes not only confidentiality but also sensitivity to the variations in adolescent development and maturity. Adolescent growth is a complex, rapid and uneven process; development varies according to age and individual circumstances.[31] As she matures, an adolescent's intellectual and emotional capacities change, and she acquires the capability to reason, solve problems rationally and understand the consequences of decisions.[32] Early adolescents aged 10 to 14 years usually lack sufficient cognitive, psychosocial and emotional maturity to understand and bear the responsibilty of pregnancy and childbirth; by contrast, older adolescents typically display the maturity to handle decisions concerning their pregnancy outcomes.[33] Within each age group, however, individual abilities vary, requiring treatment directed towards the individual patient's needs. *Pediatrics* at 46; Osofsky & Osofsky, *Teenage Pregnancy: Psychosocial Considerations*, 21 Clin. Obstet. Gynec. 1161, 1172 (1978); *Miller & Field* at 195.

SUMMARY OF ARGUMENT

These cases concern the tension between the right of a minor woman to decide, in consultation with her health care provider, whether to have an abortion and the state's interest in encouraging this decision to be made on an informed basis with the assistance and support of the minor's parents. In suggesting how this tension should be

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agers, Physicians, and the Law in New England, 6 J. Adol. Health Care 377, 380 (1985); *Miller & Field* at 204. The British Medical Association also endorses a policy of confidential treatment for adolescents. Harvard, *Medical Confidence*, 11 J. Med. Ethics 8, 9 (1985).

[31] McAnarney & Greydanus, *Adolescent Pregnancy and Abortion*, in Adolescent Medicine 403-404 (A. Hofmann & D. Greydanus 2d ed. 1989).

[32] *Miller & Field* at 203; Melton & Pliner, *Adolescent Abortion: A Psychological Analysis* in Adolescent Abortion 1 (G. Melton ed. 1986).

[33] *McAnarney & Greydanus* at 403-04.

resolved under the Constitution and the decisions of this Court, *amici* recognize that the state has a strong interest in promoting discussions between minors and their parents concerning any subject as important as health care. *Amici* routinely encourage minors to consult with their parents concerning all important health and life decisions and firmly believe that *voluntary* consultation with parents is highly beneficial to most adolescents. However, because *mandatory* parental notification places an extraordinary burden on many pregnant minors and that burden is not justified by the state's interests, this Court should hold that a state may not mandate parental involvement, whether by means of consent or by notification, without providing an effective, confidential and expeditious alternative procedure.

A. The constitutional right articulated by this Court in a line of cases following *Roe* v. *Wade*, 410 U.S. 113 (1973) ("*Roe*"), protects a woman's decision whether to terminate an unwanted pregnancy free from unwarranted interference by the state. This right extends to pregnant minors, as well as adults, because unwanted motherhood may be "exceptionally burdensome" for young women. *Bellotti* v. *Baird*, 443 U.S. 622, 642 (1979) ("*Bellotti II*"). Accordingly, this Court has recognized that despite the state's interest in furthering parental involvement in the raising of their children, the state may not constitutionally impose a parental *consent* requirement on a pregnant minor who seeks an abortion without providing her with an alternative procedure that eliminates the need to notify her parents. *Id.*

By comparison to a consent requirement, mandatory parental *notification* imposes somewhat different but nevertheless significant burdens on the minor's exercise of her rights, *viz.*, delaying or dissuading minors from seeking necessary medical care. This delay, in turn, increases the health risks to the pregnant minor, which this Court has recognized as a constitutionally significant burden. *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 450 (1983) ("*Akron I*").

Thus, as this Court recognized in *Bellotti II*, parental notification, although not equivalent to consent, imposes a significant burden on a minor's abortion rights. 443 U.S. at 647. Moreover, a requirement, such as Minnesota's, to notify both parents, even where one parent is not and has never been involved in the raising of the pregnant minor, is extremely burdensome and poses special risks to the pregnant minor.

B. This Court has held that "[s]tate restrictions inhibiting privacy rights of minors are valid only if they serve 'any significant state interest . . . that is not present in the case of an adult,'" *Carey* v. *Population Services Int'l*, 431 U.S. 678, 693 (1977) (citations omitted), and that the state must provide the Court with "more than a bare assertion . . . that the burden is connected to such a policy." *Id.* at 696. Moreover, this Court has generally held that when a fundamental right is infringed, the state must carefully tailor its statute to its legitimate objectives. *Roe*, 410 U.S. at 165; *Planned Parenthood Ass'n* v. *Ashcroft*, 462 U.S. 476, 485 n.8 (1983). In an area as sensitive as teenage abortion, the state must not be permitted to apply absolute requirements; the state must make allowances for individual differences. When judged by this standard, both the Ohio and Minnesota mandatory parental notification schemes are invalid in the absence of an effective, confidential and expeditious procedure permitting the minor to bypass notification of one or both parents, because neither statute serves carefully to advance the state's legitimate interests in the health of the minor or in fostering family integrity.

ARGUMENT

I. MANDATORY PARENTAL NOTIFICATION IMPOSES A CONSTITUTIONALLY SIGNIFICANT BURDEN ON A MINOR WOMAN'S RIGHT TO DECIDE WHETHER TO TERMINATE HER PREGNANCY AND ACCORDINGLY THE STATE MUST PROVIDE AN EXPEDITIOUS AND CONFIDENTIAL ALTERNATIVE TO MANDATORY PARENTAL NOTIFICATION.

At their core, the two cases before the Court concern the basic tension between the right of a minor woman to decide, in consultation with her health care provider, whether to have an abortion and the State's interest in encouraging this decision to be made on an informed basis with the assistance and support of the minor's parents. Minnesota has chosen to resolve this delicate issue by requiring, under burden of criminal and civil sanction, that a physician notify *both* biological parents (whether or not the parents were ever married, had custody of the child or participated in the child's rearing in any way) that their minor daughter intends to have an abortion and then wait at least 48 hours after such notice before performing the abortion. Minn. Stat. Ann. §§ 144.343(1)-(7) (West 1988). Ohio has chosen to resolve this same problem by requiring, under burden of criminal and civil sanction, that the physician personally give actual notice to at least one parent and then wait at least 24 hours after notice before performing the abortion. Ohio Rev. Code Ann. §§ 2151.85, 2505.073 and 2919.12 (Anderson Supp. 1989). Both statutes contain provisions establishing a judicial by-pass procedure intended to permit a mature minor or minor whose best interests would not be served by notification to be relieved of the mandatory requirement. Nevertheless, both states have asked this Court to hold that they are not constitutionally obligated to maintain a confidential and expeditious procedure to bypass parental notification.

This Court has clearly established that a state cannot compel a pregnant minor to obtain parental *consent* for

an abortion without providing her an alternative procedure whereby she can obtain authorization for an abortion without notifying her parents. *Bellotti II*, 443 U.S. at 643. The alternative procedure must allow the minor to show:

> either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation, with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests.

Id. at 643-44 (footnotes omitted). In addition, the alternative procedure, which can be administrative or judicial in nature,

> must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained.

Id. at 644. Because the parental consent statute at issue in *Bellotti II* failed to comply with these requirements, the Court found the Massachusetts statute unconstitutional.

This Court did not in *Bellotti II*, and has not since, resolved the exact question posed by the present cases, namely, whether a State can impose the burdens of mandatory parental *notification* on a minor attempting to exercise her constitutional right to choose an abortion without providing an effective, expeditious and anonymous by-pass procedure that does not entail parental involvement.[34] Nevertheless, in *Bellotti II*, this Court explicitly

[34] In both *H.L.* v. *Matheson*, 450 U.S. 398 (1981), and *Bellotti II*, this Court's discussion of notice provisions was in the context of notice to parents of *immature* minors (*Matheson*, 450 U.S. at 411 ("[a]s applied to immature and dependent minors. . . ."); *Bellotti II*, 443 U.S. at 640 ("[a]s immature minors often lack the ability to make fully informed choices . . .")). Moreover, there was no allegation of injury to the immature minor from parental involvement. Thus, neither *Matheson* nor *Bellotti II* resolved the issue presented by the cross petition in *Hodgson* and appeal in *Akron II*, both of which involve statutes that apply to mature minors as well as immature dependent minors whose best interests would not be served by parental involvement. *See Matheson*, 450 U.S. at 414 (Powell, J., concurring).

rejected the statutory scheme there because it did not permit "every minor [to] have the opportunity—if she so desires—to go directly to a court without first *consulting or notifying* her parents." *Id.* at 647 (emphasis added). The Court's holding and reasoning in *Bellotti II* reflect a recognition that mandatory parental involvement, whether in the form of consent, consultation or mere notice, "would impose an undue burden upon the exercise by minors of the right to seek an abortion." *Id.*

Obviously, there is a difference between a statute that gives one or more parents an absolute veto over the minor child's exercise of her constitutional rights and a statute that requires one or more parents to be notified. But the constitutional analysis does not turn on whether the state-imposed obstacle is absolute; that merely makes the case easier to decide. The analysis depends upon whether the statutory scheme imposes a sufficient burden on the exercise of the minor's right to require the state to come forward to justify the restrictions. See *Akron I*, 462 U.S. at 449-51; *Matheson*, 450 U.S. at 414 (Powell, J., concurring) (noting that majority did not decide whether notification requirement burdens minor's rights if notice is not in her best interests). In light of the very substantial burden imposed by a mandatory parental notification requirement, *Bellotti II*, 443 U.S. at 647, and the lack of sufficient justification for such a requirement as applied to a sizable class of mature minors and those for whom it would be in their best interests to have an abortion without notifying their parents, this Court should hold that an effective, confidential and expeditious alternative procedure is required whenever a state burdens a minor's constitutional right to choose an abortion by mandating parental involvement, whether that involvement takes the form of mandatory notification or mandatory consent.

A. Mandatory Parental Notification Imposes A Constitutionally Significant Burden On A Minor Woman's Right To Decide Whether To Terminate Her Pregnancy.

The most serious burden imposed by mandatory parental notification is the impact it has on adolescent health. This burden has two aspects: first, by requiring notification, the statutes deter adolescents from seeking health care and second, the notification requirements cause adolescents to delay seeking care which in turn increases the medical risks to them.

First, the statutes at issue in these cases both clearly abrogate the confidentiality that is at the core of the physician-patient relationship by requiring the physician to notify one (Ohio) or both (Minnesota) of the minor woman's parents of her intent to obtain an abortion. It is well documented that adolescents are particularly concerned with keeping information concerning their sexual/medical history confidential and that perceived threats to confidentiality are a primary factor in an adolescent's propensity to delay or even forgo seeking health care. See *supra* pp. 10-11. Noting that this issue of confidentiality is "a significant access barrier to health care," those in the medical community who primarily provide care to adolescents recently issued guidelines calling for health care professionals, *inter alia*, to accord adolescent patients the same confidentiality as that accorded to adult patients.[35]

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[35] *See* App., *infra*, 1a-2a. The actual operation of a mandatory parental involvement statute in Massachusetts demonstrates that the concern with erecting barriers to access to health care is more than hypothetical—when confronted with mandatory parental consent, one third of the minors seeking an abortion are traveling outside the state to obtain an abortion in a jurisdiction that does not require parental notice. Cartoof & Klerman, *Parental Consent for Abortion: Impact of the Massachusetts Law*, 76 Am. J. Pub. Health 397, 400 (1986). Similarly, the impact of the Minnesota statute has been to delay adolescents in obtaining abortions. *See* Hodg. App. 135a.

Most states have recognized the devastating impact on care that occurs when an adolescent patient's confidentiality is breached and have responded explicitly by exempting adolescents from parental consent *or even notification* when adolescents seek medical assistance for prenatal care, venereal disease or sexually transmitted diseases in general, and drug or alcohol abuse.[36] Minnesota and Ohio are among those states.[37] Minn. Stat. § 144.343 (1) (West 1988); Ohio Rev. Code Ann. §§ 3709.24.1, 3719.01 2 and 5122.04 (Anderson Supp. 1989).

Second, the experience of health care providers, the sound judgment of state legislators and the actual operation of parental notification statutes confirm that mandatory parental notification leads many minors significantly to delay obtaining care. The additional delay provoked by a mandatory parental notification statute can cause a significant increase in medical risk for many minors. Although abortion is a relatively low-risk medical procedure for the pregnant woman,[38] health risks increase with the gestational age at the time of the abortion. Mortality due to abortion, although quite low in comparison with other common medical procedures, increases approximately 20 percent for each week of gestation from 8 to 15 weeks and even more after 15 weeks.[39]

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[36] Hodg. Pet. Brf. App. A-8 to A-18 (listing states in each of these categories). For example, states permit adolescents to consent to confidential childbirth care, including delivery by cesarean section. These procedures pose greater health risks to adolescents than abortion. See *supra* pp. 5-8.

[37] The five-year experience with a two-parent notification requirement in Minnesota illustrates the directness of the correlation between breaches in confidentiality and delay in obtaining an abortion —the percentage of women under the age of 17 who obtained abortions in their second trimester was 18.4 percent in 1978; by 1983, after the statute had been in effect for several years, that figure had increased to 23 percent while the figures for Minnesota women 18 and older showed no such dramatic increase in late abortions. Hodg. App. 135a.

[38] *See supra* pp. 5-6.

[39] C. Tietze & S. Henshaw, *Induced Abortion: A World Review 1986* 109-10 (6th ed. 1986).

As discussed above, it is well-established that adolescents are more likely than adult women to postpone seeking all pregnancy related medical care, including abortions. See *supra* p. 9. Because minors delay seeking an abortion longer than adults, any additional delay will pose a greater risk to their health than would such a delay for adult women seeking an abortion. When added to the other factors that cause adolescents to delay seeking abortions, a mandatory parental notification requirement will push some minors into the second trimester before they receive an abortion.[40] If that occurs, the risk of medical complications increases substantially.[41] Moreover, if the minor ultimately decides not to have an abortion, mandatory parental notification will have delayed her in seeking appropriate prenatal care, causing increased health risks to her and to her baby. See *supra*, at 9.

Mandatory waiting periods, such as the 48-hour requirement in Minnesota and the 24-hour requirement in Ohio, exacerbate the delay. As a practical matter, mandatory waiting periods often result in the minor having to make a second trip to the health care facility with additional delays caused by scheduling.[42] If, as is often

[40] The district court specifically found that the effective delay caused by Minnesota's two-parent notification requirement when coupled with the 48-hour waiting period could reach one week or more. Hodg. App. 23a. Such a delay could, the court found, result in a woman having a second trimester abortion. *Id.*

[41] *C. Tietze & S. Henshaw* at 103-04, 110.

[42] Although in theory a minor can call ahead to the physician, who can then notify the parent or parents and schedule a single appointment for some time after the expiration of the mandatory waiting period, *see, e.g.*, Hodg. Brf. of Cross Pet. 40), many physicians are unwilling to notify the minor's parents that an abortion will be performed on their daughter in 24 or 48 hours, if the physician has never met the minor, examined her, confirmed her pregnancy or discussed alternatives with her. *See, e.g.*, AAP, Comm. on Adolescence, *Counseling the Adolescent About Pregnancy Options*, 83 Pediatrics 135, 136 (1989) ("information [about the existence of a pregnancy] should always be given in a personal and private setting, preferably not by telephone").

the case, the minor must make a second trip to the physician, there will be additional expense and delay. The additional delay, in turn, compounds the increased medical risk of a later abortion.[43]

B. Mandatory Parental Notification Required In All Cases Is Not Tailored To The States' Interests In Protecting The Adolescent's Health Or In Promoting Family Integrity.

The precise formula for reviewing the constitutionality of statutes that substantially burden a pregnant minor's abortion right has never been articulated by this Court, but it is clear that the state must "act with particular sensitivity when it legislates to foster parental involvement" in a minor's decision whether to terminate a pregnancy. *Bellotti II*, 443 U.S. at 642. Thus, the state must advance a "significant state interest" in the burdening regulation, *Carey* v. *Population Services Int'l*, 431 U.S. at 693 (plurality opinion), and the state must do more than simply assert that the statute advances the state's significant interest. *Id.* at 696.

Moreover, when a fundamental right is infringed, this Court has held that the State must carefully tailor its statute to its legitimate objectives. See *Roe*, 410 U.S. at 165; *Ashcroft*, 462 U.S. at 485 n.8, *Akron I*, 462 U.S. at 438. *Amici* submit that no different approach is warranted in dealing with minors, although they recognize that this Court has held that additional state interests exist in the context of minors. *Cf. Matheson*, 450 U.S. at 410-11. And even if a state need not "fine-tune" its statutes in this setting, it would be wholly inconsistent with the fact that the minor is exercising a fundamental right to permit the State to further its interests in ways that are unjustifiably overbroad. Because it is clear that

[43] There is also evidence that a mandatory waiting period itself creates additional stress and anxiety that further compounds the health risks of abortion. Lupfer & Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Fam. Plann. Persp. 75, 77 (1981).

the opportunity for an individualized determination is necessary to permit many minors to exercise their rights and to ensure that the State's interest in protecting their health is achieved, this Court should hold that a state must provide an effective, confidential and expeditious alternative to parental notification.

Minnesota and Ohio attempt to justify the significant burden they impose by arguing that their requirements serve several important state interests. However, even a cursory examination of the parental notification requirement demonstrates that for a significant number of minors, the statutes, if applied without exception, will fail to advance any purported state interest.

1. One of the primary justifications advanced by Minnesota and Ohio is to further parental involvement in raising their children.[44] However, for a significant number of minors, the requirement fails to promote the state's interest. First, studies have shown that a substantial number of adolescents voluntarily notify one or both parents in the absence of any statute and that among younger adolescents—those 15 and younger—over 75 percent voluntarily informed their parents.[45] Because the state's putative interest is in providing guidance to *immature* minors,[46] it is particularly significant that younger adolescents overwhelmingly choose to involve one or both parents voluntarily. For all those minors who voluntarily inform a parent, the statutory notice requirement serves only to delay effectuation of a decision that benefited from familial involvement.[47] And, as amply documented, the delay created by this statutory requirement entails an increased health risk to the minor.

Second, in the absence of an effective by-pass procedure neither statute would provide any exception when notification reasonably can be expected to have disruptive and perhaps dangerous consequences. In most situations, it is helpful to involve parents when a minor is faced with any medical treatment decision, including whether or not to terminate a pregnancy. It is for that reason that several of the *amici* have issued a policy statement directing their members to use "every reasonable effort to encourage the adolescent to involve parents" in providing medical care and counseling. App., *infra*, 1a. However, in that same statement, the health care providers caution that "the health risks to the adolescents are so impelling that . . . deference to parental involvement should not stand in the way of needed health care." *Id.* at 2a.

This policy statement reflects the fact that there are circumstances, unfortunately too frequent, in which parental involvement will be harmful to the patient's health and not beneficial to family relationships. The initial parental reaction to a minor daughter's pregnancy frequently involves anger and can lead to a family crisis.[48] In families with a history of physical or sexual abuse, such an announcement may precipitate a violent reaction.[49] It is thus not surprising that a substantial

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[44] Mandatory notification is designed "to serve the state's substantial and legitimate interest in the family-based child-rearing process" (Hodg. Brf. of Cross Pet. 8); it assists in "promoting parental consultation" (Akron II Brf. of Appellant 24).

[45] Torres, Forrest & Eismann, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Fam. Plann. Persp. 284, 287-90 (1980); Clary, *Minor Women Obtaining Abortions: A Study of Parental Notification in a Metropolitan Area*, 72 Am. J. Pub. Health 283, 284 (1982); Rosen, *Adolescent Pregnancy Decision-making: Are Parents Important?*, 15 Adolescence 44 (1980).

[46] *Bellotti II*, 443 U.S. at 640; *Matheson*, 450 U.S. at 411.

[47] In Minnesota, the court found that there was no increase in the proportion of minors who notified their parents because of the law (Hodg. Pet. App. 41a) and, moreover, some minors chose to utilize the by-pass procedure rather than tell both parents although they would have been willing to tell one parent. Hodg. Pet. App. 31a.

[48] Osofsky & Osofsky, *Teenage Pregnancy: Psychosocial Considerations*, 21 Clin. Obstet. Gynec. 1161, 1164-65 (1978).

[49] A recent government study has estimated that at least one million children and adolescents have been harmed by abuse or neglect. National Center on Child Abuse and Neglect, U.S. Dep't of

percentage of the minors who do not voluntarily inform their parents of their pregnancy and planned abortion indicate that their reluctance stems from fear of physical punishment or other extreme response.[50] Obviously, such responses do not promote the minor's health; they seriously jeopardize it. Moreover, even if the fear of a harsh response, in fact, proves incorrect, the fear and attempt to avoid notification can lead to delay in seeking medical care that in turn increases the health risks to the pregnant minor. See *supra* pp. 9-10. Finally, as discussed below at 26, notification to a non-custodial, long absent parent, as required under the Minnesota statute, may well result in familial discord and disruption of the custodial family, which is the antithesis of the family integrity contemplated by the legislature.

2. Many states, including Ohio and Minnesota, have argued that parental notification or consent serves an important state interest in protecting the minor woman's health by allowing one or both parents the opportunity to provide the physician with medical information of which the physician would otherwise be unaware and by ensuring that a parent is alert to the signs of potential medical complications from the procedure. Akron II Brf. of Appellant 46-47. Hodg. Brf. of Cross Pet. 34-35. Although the Court has postulated such an interest, *Matheson*, 450 U.S. at 411, in fact breaching a minor's confidentiality jeopardizes the state's interest in assuring the minor's health. Not only are parents frequently unaware

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Health and Human Services, *Study of National Incidence and Prevalence of Child Abuse and Neglect 1988* xx (1989).

[50] *Clary* at 284. *See also* Blum, Resnick & Stark, *The Impact of a Parental Notification Law on Adolescent Decision-Making*, 77 Am. J. Pub. Health 619, 620 (1987) (anticipated family conflict was chief reason adolescents chose not to inform parents of their pregnancy); Donovan, *Judging Teenagers: How Minors Fare When They Seek Court-Authorized Abortions*, 15 Fam. Plann. Persp. 259, 262 (1983).

of important aspects of their minor children's medical history, particularly those related to sexual activity, drug and alcohol use,[51] but more importantly, there is a serious risk that by breaching the minor's confidentiality, the statute will operate to deprive health care providers of necessary medical information that only the minor knows if, as is well-documented, she is unwilling to be candid about her relevant medical history without an assurance of confidentiality from the health care provider.[52]

3. A mandatory, two-parent notification requirement, such as Minnesota's, is completely unjustified. As we have shown previously, the burdens imposed by a mandatory parental notification scheme are greatly increased by the addition in Minnesota of a requirement that *both* biological parents must be notified of their minor daughter's intent to obtain an abortion. Thus, even if the Ohio statute could be defended on the ground that the State's interests justify the burden imposed by a one-parent notification requirement, which it cannot, it is clear beyond doubt that Minnesota's two-parent requirement without exceptions is unconstitutional.

a. By imposing a requirement that the physician notify both biological parents before performing an abortion on a minor, Minnesota has treated abortion differently than any other medical procedure. In areas that do not deal with sexuality or substance abuse, states require, at most, a single parent's consent before performing medical procedures on a minor. This is true regardless of the immaturity of the minor or the dangerousness of the procedure.[53] Thus, in Minnesota, a physician could

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[51] *See* AAP, Comm. on Adolescence, *Role of the Pediatrician in Management of Sexually Transmitted Diseases in Children and Adolescents*, 79 Pediatrics 454, 454 (1987); *Rosen* at 44.

[52] Roemer, *Legislation on Contraception and Abortion for Adolescents*, 16 Fam. Plann. Persp. 241, 247 (1985) (access is fostered by assuring confidentiality of abortion services).

[53] Even the federal regulations governing the participation of children in medical research deem consent by one parent to be

face the anomalous situation that he could perform heart surgery on an infant with the consent of a single parent, but would be subjected to criminal and civil sanction if he performed an early first trimester abortion on a 17 year old with her mother's written consent. The obvious purpose of this scheme is to discourage an adolescent from exercising her constitutional right to have an abortion and the practical effect is to jeopardize the minor's health.

b. The Minnesota statute fails to make exceptions to the two-parent notification requirement in a number of circumstances where notification of the second parent could not possibly serve any state interest in fostering family communication, protecting the minor's health or in providing an immature minor with guidance in important decisionmaking. For example, the statute makes no exception for a long-absent biological parent, a parent who has indicated no interest or willingness to become involved in the care and rearing of the minor daughter, or even an abusive parent (except in the narrow circumstances where the minor is willing to report the physical or sexual abuse to officials who will begin formal investigation of the charges). In none of these cases can the statutory requirement of notifying *both* biological parents be said to serve any legitimate state interest.[54] In sum, the two-parent notification requirement of the Minnesota statute utterly fails to advance any legitimate state interests in a carefully tailored fashion.

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sufficient except where the research poses greater than minimal risk *and* the procedure offers no prospect of direct benefit to the child or is so experimental as to be classified as "not otherwise approvable." 45 C.F.R. §§ 46.406 and 46.407 (1988).

[54] This Court's decision in *Bellotti II* is not to the contrary. In that case, this Court concluded that the requirement of obtaining the consent of both parents did not constitutionally burden a minor's right to seek an abortion "[a]t least when the parents are together and the pregnant minor is living at home." *Bellotti II*, 443 U.S. at 649. However, the statute at issue in *Hodgson*, as drawn and as applied, clearly covers minors whose parents are not and have never been together in the same household with the minor.

C. In Order To Serve Their Interests, As Required By The Constitution, Both Ohio and Minnesota Are Obliged To Provide Some Opportunity For A Minor To By-Pass Having To Provide Notice To Either Or Both Parents, Respectively.

As this Court has recognized, despite the State's interest in encouraging familial communication about important life decisions by minors, the "need to preserve the constitutional right and the unique nature of the abortion decision . . . require a State to act with particular sensitivity when it legislates to foster parental involvement in this matter." *Bellotti II*, 443 at 642. Because of the extraordinary burdens imposed by a parental notification requirement and the special developmental characteristics of adolescents, if required parental notice is permitted, the state must provide an effective alternative procedure that will both protect the minor's fundamental right to choose appropriate health care and accommodate the state's legitimate interests.[55]

For the purpose of determining the need for a by-pass procedure, it is significant that the parental notification requirements at issue in these cases apply to mature minors, as well as to immature minors.[56] This Court has recognized that a minor's maturity is of particular importance in the context of a state statute restricting a minor's abortion right. Thus, despite the general au-

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[55] As this Court noted in *Bellotti II*, the alternative procedure need not be judicial. 443 U.S. at 643 n. 22. In light of the serious deficiencies of some judicial by-pass procedures, *cf.* Hodg. Cert. Pet. App. 27a, 82a, 93a (findings of district court), it may well be that an administrative procedure would be more effective in reducing delay, trauma to the minor and risk to her health and well-being.

[56] The present cases thus involve a very different issue from that posed in *Matheson* where the minor class challenging the statute made no allegation based on maturity. *Matheson*, 450 U.S. at 412 n.22 (because the particular class was one of immature minors, the case does not require the Court to determine the circumstances in which a state must provide an alternative to parental notification); *id.* at 414 (Powell, J., concurring).

thority that is given to the state to "resort to objective, though inevitably arbitrary criteria such as age limits" when regulating the legal rights of minors, "the peculiar nature of the abortion decision *requires the opportunity for case-by-case evaluations of the maturity of pregnant minors.*" *Bellotti II*, 443 U.S. at 643-44 n.23 (emphasis added). In the absence of a by-pass procedure, neither of the parental notification schemes at issue in these cases would permit any such individualized evaluation of the pregnant minor's maturity.

There are considerable variations in the maturity of adolescents; a substantial number of older adolescents (those 16 and 17 years old) and even some younger adolescents are sufficiently mature to make reasoned, thoughtful and competent decisions about such medically and ethically complex subjects as whether or not to terminate a pregnancy. See *supra* p. 12. This is not to say that mature minors generally will not profit from involving their parents in a decision about abortion—most would and, in fact, most do. But the State's interest in protecting a minor from the consequences of a choice that is not informed and mature (*Bellotti II*, 443 U.S. at 635) would not be advanced by requiring a mature minor to involve her parents in all circumstances. Given that the vast majority of adolescent pregnancies and abortions occur among 16-17 year olds, *supra*, at 4 & n.3, 5, and that many of them have attained intellectual and emotional maturity, *supra*, at 12, absolute enforcement of parental notification would impose significant burdens on a large class of minors without promoting the State's interest in protecting immature minors.[57] Moreover, failure to provide an alternative to

[57] The magnitude of this case is illustrated by the actual experience in Minnesota where approximately half of the minors seeking abortions under the parental notification statute chose to utilize the by-pass procedure and of that group (almost all age 16 or older), only a handful were determined both to be immature and not to be better served by having an abortion. Hodg. Cert. App. 27a (findings of the district court).

parental notification would impose an "exceptional[] burden[]" on those immature minors whose best interests would be served by having an abortion without involving their parents. *Bellotti II*, 443 U.S. at 642.

This Court has previously held that a constitutionally adequate by-pass must assure the minor's confidentiality; it must be swift; and it must entail an examination into the individual pregnant minor's maturity and, if she is found not to be mature, into her best interests. *Bellotti II*, 443 U.S. at 643-44. See also *Ashcroft*, 462 U.S. at 490-93 and *Akron I*, 462 U.S. at 438-40. There is no reason that a by-pass procedure for a parental notification requirement should differ from the sound dictates of *Bellotti II*: the burden imposed by breaching a minor's confidentiality is substantially identical whether the State requires parental notification or parental consent; the burden of delay in the two cases is exactly the same; and the State's interest in protecting the minor from the consequences of immature or unwise decisions does not vary depending on the means the State has chosen to encourage parental involvement. Moreover, as acknowledged by this Court (*Bellotti II*, 443 U.S. at 644 n.23) and amply demonstrated by health care professionals, minors differ substantially in their maturity and in what would advance their best wishes, and thus an individualized by-pass assessment is absolutely essential to achieve narrowly the State's purposes if parental notice is required.

CONCLUSION

For the foregoing reasons, the decision of the Sixth Circuit should be affirmed, and the decision of the Eighth Circuit should be affirmed to the extent that it holds that an effective by-pass procedure must be provided if the State is permitted to require parental notification.

Respectfully submitted,

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October 13, 1989

APPENDIX

CONFIDENTIALITY IN ADOLESCENT HEALTH CARE

POLICY STATEMENT (1988)

This statement was approved as policy by the following organizations: the American Academy of Family Physicians; the American Academy of Pediatrics; the American College of Obstetricians and Gynecologists; the Nurses' Association of the American College of Obstetricians and Gynecologists; and the National Medical Association.

Adolescents tend to underutilize existing health care resources. The issue of confidentiality has been identified, by both providers and young people themselves, as a significant access barrier to health care.

Adolescents in the United States, while generally considered healthy, have a range of problems, including some of such severity as to jeopardize their development and health, their future opportunities and even their lives. To illustrate, there is an urgent need to reduce the incidence of adolescent suicide, substance abuse, and sexually transmitted diseases and unintended pregnancy.

As the primary providers of health care to adolescents, we urge the following principles for the guidance of our professional members and for broad consideration in the development of public policy:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.

2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.

3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decision-making responsibility for their children with these providers. At the time providers establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:

- The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.

- The adolescent must understand under what circumstances (e.g., life-threatening emergency), the provider will abrogate this confidentiality.

- Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.

4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constraints on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care.